Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: HARISON NDAIRIHO KULE**	**Service Date**	**:21-Aug-2025** **Network** : Green
Card No	**: I035-029-122758921-01**	**Health Provider**	**:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	**: HARISON NDAIRIHO KULE**	**Doctor's Name**	**:KEERTHANA**
Payer Name	**: SALAMA – Islamic Arab Insurance Company**	**Co-Insurance**	:
TPA	**: E CARE - Blue Network**	**Remarks**	:
Validity	**: 28-05-2025** To **27-05-2026**		
Gender	**: Male**		
Date Of Birth	**: 12-Feb-1995**		
Patient's Tel No	**: 0543020949**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PC LOSS OF APPEPITE,BITTER TASTE,ABDOMINAL PAIN HOPC pt presents with complaints of severe left sided abdominal pain,loss of appetite,bitter taste,nauseous since 10-12 days He feels dizzy and tired O\E he looks pale and dehydrated No history of drug allergy **Duration:**

Vitals: Temp : 36.2 Bp :120 Pulse :80 Resp :18

Clinical Findings:

Diagnosis: K29.00 - Acute gastritis without bleeding,R11.2 - Nausea with vomiting, unspecified,K21.9 - Gastro-esophageal reflux disease without esophagitis,B96.81 - Helicobacter pylori as the cause of diseases classd elswhr,E86.0 - Dehydration,R42 - Dizziness and giddiness, **Date of Onset** :21/14/2025

Requested Investigations: 0005-136504-1021, SCOPINAL,87338, IAAD EIA HPYLORI STOOL,0005-242802-0781, PANTONIX 40MG I.V.,76705, ULTRASOUND ABDOMINAL REAL TIME W/IMAGE LIMITED,0439-152905-1001, LACTATED RINGERS INJECTION USP,9, Consultation GP,96360, HYDRATION IV INFUSION INIT,96374, THER/PROPH/DIAG INJ IV PUSH **Estimated Cost** :

Prescriptions: 0135-116604-1171 - (METRONIDAZOLE : 500 MG) TABLETS,0219-533801-0391 - (ESOMEPRAZOLE (AS MAGNESIUM) : 20 MG) FILM COATED TABLETS,4937-189409-1111 - (CALCIUM CARBONATE : 80 MG/5ML) (SODIUM BICARBONATE : 133.5 MG/5ML) (SODIUM ALGINATE : 250 MG/5ML) SUSPENSION, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : KEERTHANA

Stamp :

د. كيرثانا راني بادييورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذم م
CITICARE MEDICAL CENTER LLC

Signature :

Date : 21-Aug-2025

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Patient 's signature{Parent if minor} :

Date : 21-Aug-2025